

2011 COMMUNITY MENTAL HEALTH SUMMER STAKEHOLDER SERIES**DATE: August 25, 2011 LOCATION: Los Angeles, CA****Participants**

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| 115 | Consumers/Family Members/Consumer Advocates |
| 93 | Providers |
| 33 | County Representatives |
| 06 | Other |
| 13 | Phone Participants |
| 260 | Total Participants |

Pre-Meeting Education Session- Questions/Comments

- Is there going to be an explanation of the impact of moving these functions to a particular entity? What are the potential outcomes?
- What are the options for consideration? **There are many options due to the stakeholder process: 1) DHCS could create a Division of Mental Health; 2) DMH could continue to operate with a Community Services Division (status quo); 3) What do you think should happen?**
- Is this process about state or local functions? **This process will help us to determine which functions should stay at the state level and who should "house" them and which functions should shift to the local level.**
- Does the local stakeholder process input get reviewed at the state level, for the purposes of this process? Marv Southard holds stakeholder meetings in Los Angeles, some of that information gathered might be useful to you. **That is a great suggestion to make during the break-out sessions later.**
- Will DMH continue to be under the CA Health and Human Services Agency? If the programs/functions move, will the money follow? Yes, the functions will stay under CHHS. The money will [likely] follow the programs.
- What will be the role of the MHSOAC and/or CalMHSA? **AB100 clarifies some specific functions of the MHSOAC. This stakeholder process (especially in break-outs) will give participants and opportunity to weigh in on the MHSOAC and CalMHSA.**

Background and Context Questions/Comments

- What are the possible options for these functions?
 1. **Option One: Move all functions to DHCS**
 2. **Option Two: Create a new behavioral health department with both alcohol and drug services and mental health services**
 3. **Option Three: Move Medi-Cal functions to DHCS and align remaining functions with various appropriate state level agencies**
 4. **Option Four: Retain a stand-alone Department of Mental Health**
- How will the creation of a new department of behavioral health un-do or align with the Governor's direction regarding the elimination of DMH and ADP? **AB100, AB102, and AB106 speak only to the transfer of Medi-Cal services.**

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- Is it true that DHCS does not want all of the “qualitative functions”? If so, is transfer of remaining functions to DHCS even an option? **They are trying to figure out what they can take on. The new Director, Toby Douglas, is working through these issues.**
- With the transition, are there any guarantees, regarding MHSA money NOT being used for other types of services instead of mental health? **There is a state level group discussing this issue.**
- We don’t know enough about the options. There should be another process to educate consumers and get feedback.

Based upon today’s presentation, what are the changes in mental health at the state level that stand out for you?

- What is the jurisdiction of the Department of Corrections [as it relates to the state hospitals]? **DMH will, at some level, become the Department of State Hospitals. Can there be a collective approach to run the hospitals? This question is being considered. NAMI didn’t like this idea about a connection between the Receiver, Hospitals and CDCR. But, 93% of the Hospital population is forensic commitments; only 7% is civil commitments.**
- There is a possibility for fragmentation with the transfer to DHCS. There are important functions that need to NOT be glossed over (e.g., licensing and certification and Office of Consumer Affairs). Let’s think about these more in the break-outs.
- The budget resources being used by the Governor and taken from consumers is wrong.
- Consumers need to continue to be a part of the discussion/process. This can’t be the only opportunity for input.
- Regarding the 19 positions, there doesn’t seem to be a focus on cultural competence. Especially, the Office of Multicultural Services. What is the plan? Will there be a new Chief hired to replace Rachel Guerrero? **This is a big concern all over the State. The OMS still exists: Kimberly Knifong and Marina Augusto. The suggestion to hire a Chief/leader will be in the Summary Report to the Legislature.**
- The idea of moving children’s funding [AB3632] to Education is a horrible idea. The teachers don’t have the psychiatric training. **That money was already moved to CDE.**
- How does health care reform (2014) align with this process? DHCS is the single state agency for health care reform. The options (1-4) will have a plan for health care reform built in to them.
- The message about Prop 63 MHSA, Prevention and Innovation, needs to be brought back to Sacramento. These are new kinds of services, not within the medical model.
- Please make sure to include deaf culture in additional to racial/ethnic cultural competence.
- What is the role of the local Mental Health Boards/Commissions? **We have had good communication with Kerry Martin and local county mental health directors to get feedback/involvement and strengthen partnership with the local Boards and Commissions.**

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- Opportunities for the Administration to understand what consumers are feeling; their wellbeing needs to be considered.
- This is an opportunity to bring logic to an illogical system. We can reorganize services to fit needs of the people.
- Don't make it more complicated = focus on well being
- "Local Control" is disempowering for people. Where is the accountability? We need to create an enforcement system.
- We need to focus on client councils, wellness and recovery; this is already being done in other organizations.
- How do we get the services back to the people? Income?
- Give people skills and find them appropriate employment.
- More direct consumer input.
- Create uniformity across sites for services.
- Embrace the idea of consumers and leadership to work together. We need to bring consumers and family members into a leadership role across all services systems. The same goes for LPS Conservators.
- Reduce bureaucracy and create clearer lines of community.
- "Out w/ the old, in w/the new"
 - Emphasize innovation, go for holistic approach.
 - Streamline of organization = take away the middleman.
 - Accountability
 - Commissions and Boards need best practices.
 - 5604 mandate
- We only need local boards and counties, board of supervisors needs to be responsible.
- MHSOAC oversees MHSA
- This is an opportunity to eliminate the state planning council.
- Measure outcomes over time
- Integrate mental health and alcohol and drug programs. Rethink long term recovery strategies under mental health. Emphasize wellness and recovery approach within the context of alcohol and drug services.
- As a patient advocate at the state level, if we choose to keep AOD and MH services separate, IF there is a Deputy Director for both, it is best to keep it the separate the way that it is. We need expertise for these populations.
- I feel that 70% of consumers have alcohol and drug issues, then they should be connected more (co-occurring disorders).
- Will DMH go away? How will this work? What is the ultimate reason for the integration? Why is this happening?
- Is this part of Obama's federal health care reform (ACA)?
- In the past, things were run poorly, but now things are better for consumers and family members. I am concerned that this will change for us.
- Are local providers under the authority of mental health boards?

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- What about small cities (or counties)? Will there be a difference between those that have more resources and those that have less resources? How do we balance that issue? My nephew had to come to a larger county to get more services. Counties need sufficient resources for our families and consumers.
- Can the funding for a client/consumer be transferred to where they need to be? The oversight at the local level can't support this well.
- Are other states doing this (move things locally)?
- What will happen with veterans with PTSD? Will they continue to get services?
- We need to have a voice for families, parents, caregivers, and clients at the state and/or county level.
- This is a large county (land/geographically) but here are no transportation services or public transit. In Santa Clarita, the programs are too spread out.
- We need to build integrated systems for alcohol & drug services, mental health, and physical health.
- This is an opportunity for local control and to address disparities but we need safeguards to ensure community participation. We need to avoid the medical model.
- Provide stipends for community leaders to work on prevention.
- We need opportunities for youth involvement at the state and local level.
- As a parent partner, I have a huge concern that not all opportunities are positive; there are also opportunities for discrimination for unserved communities. Access to resources is scarce.
- Client operated services can be increased and improved.
- New employment opportunities for client/family members at the state level.
- New funding for programs in the inner cities.
- The reason that the Governor is making these changes is to reduce state funding, realignment is good for counties.

County Representatives and Providers

- Consumers in the County didn't get information on MHSA-television information about the MHSA-consumers need information on how to work with mental health issues.
- Increased access
- Advocacy groups work with consultants so consumer voices can be heard
- I have concerns about services for deaf and hard of hearing children
- Deaf and hard of hearing individuals need to be counted as a part of the under-represented/unserved populations.
- This is a good opportunity to meld co-occurring disorders together, keep things from slipping through the cracks.
- Funding for adult day health care centers is being eliminated, what DMH will do to continue services? There are 18,000 in Los Angeles.
- School districts are the largest mental health providers. They are the first line, but the most underfunded.
- To facilitate improvement of mental health services, make documentation/paperwork more uniform, easier to understand, a "boilerplate" to provide services. Design a standardized process from county to county.
- As we try to reduce disparities in access to services for local communities (under-represented ethnic communities) we need to increase cultural competency.

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- Opportunity for professionals and service extenders to work together.
- Opportunity for alcohol and drug providers and mental health services to work together.
- I am concerned that AOD will be subsumed under mental health issues.
- I don't believe there is sufficient training for consumers in MHSA.
- Under MHSA, there is an opportunity for outreach, placement, and engagement in shelters. We need more people to work in shelters, now up to 600 people per night.

Phone Participants

- If stakeholders truly get a say and their comments are genuinely incorporated into the plan, there is potential for many opportunities.
- More funding at the local level will be beneficial for consumers because more resources will be available at the local level.
- There is an opportunity for standardization (statewide) of how services are provided at the county level.
- This is an opportunity to establish a baseline level of services and accountability.
- Current rules and regulations surrounding MHSA funds are too strict and prohibitive. Many people are not able to access all the services they need because of these rules. This is an opportunity to remove many of these barriers and be able to provide services that are tailored to certain populations.
- Currently, there is a disparity between the way in which Medi-Cal services and community mental health services are provided and funded. This is an opportunity to balance out this disparity.

**Which entity should assume responsibility for the functions/programs listed?
What functions/programs are missing from the list?**

Consumers/Family Members/Community Advocates

- Consolidation of the organization
- I want CalMHSA to go and the function of financial oversight to go to the locals.
- If funding goes to CalMHSA, will the people still get the services?
- [16 group members wanted CalMHSA to have financial oversight]
- What's the real reason the Administration wants to move this to the local authority?
- When Prop 63 passed, we got a community process. That is going great. We don't want this to change at all.
- Housing needs to stay local. We know what the need is. In Sacramento, you don't know our needs. It is best to go from local to state (resources to reporting).
- My son receives services through LA County DMH, we like it there. All of the functions should go there.
- What does the CMHPC do? [14 people voted for compliance/quality improvement functions to go to the CMHPC]
- My son is sick and the police criminalize him. They don't listen to him or understand his illness. He's on probation right now; doesn't make any money. So the family suffers the burden. This should not happen in America. They are not treated with access to services, his is sick and needs supports. He asks local agencies for help, not to

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criminalize him, but no one helps. They want to keep him institutionalized for 1 year. It is expensive to institutionalize people, this transition will help keep them out of that level of services.

- In the Cambodian community, mental health is a disgrace. They want stigma to be taken care of. It is hard to get help.
- [25 votes for stigma to go to CalMHSA]
- EMHI: I have a son getting great services.
- [26 votes to keep EMHI at the state DMH]
- Technical assistance needs state oversight; the ability to do this is at higher levels, like SAMHSA.
- As much local control as possible; limit the state role. The county makes the best decisions for counties.
- Does the amount of positions limit the focus on Prevention and Early Intervention? It can't all be Medi-Cal services, focus on prevention.
- NAMI CA opposes the idea of everything being put under DHCS. CCMH came up with 22 non Medi-Cal functions.
- Mental health needs a home: the Department of Mental Health and Alcohol & Drug Services.
- I concur with NAMI CA, mental health needs a home.
- Other departments may lack the mental health expertise to provide proper services.
- In a climate of reduced funding/ is there a danger of a loss of commitment to closing cultural gaps of disparities?
- What about the aging population?
- The process is moving too fast to permit adequate input, especially given the size of LA.
- The MHSA was supposed to be transformative, voluntary services. With a lack of state level oversight, who will ensure that services will be voluntary?
- Transportation is an issue that needs to be addressed at the local level.
- If funding is transferred to counties, there needs to be a strategic plan to guarantee funds are used for mental health services, not other types of services.

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- The overall mental health budget should be at the state level, not just reversion.
- Before MHSA, mental health services weren't guaranteed.. No fragmentation of services, all programs should be like MHSA programs. That would be a dream come true.
- Don't make mental health services a "step child".
- Always emphasize cultural competence.
- The mental health community is very fragmented. We need a voice at the state level to organize us as a group.
- People are concerned that they don't have enough detailed information to make "arbitrary" decisions where these programs should go.
- Why are we reinventing the wheel? Why are we allowing the Governor to fragment these services?
- If the functions move to a new organization, will sufficient funds/resources go with the functions?
- We know how many positions DMH has, do we know how many positions are in the other departments?
- If we shift functions to different departments, there won't be sufficient training for new departments can do the work.

Phone Participants

- The state should not decide how counties are spending funds; however, they should retain oversight to ensure that funds are being spent appropriately.
- Counties (local) should assume responsibility of Suicide Prevention, Stigma and Discrimination and Multicultural Services because they are more equipped to handle these functions. The local level has a better grasp of what is happening in the community and where the needs are greatest in these programs.
- The state should retain responsibility of Financial Oversight, Issue Resolution, Technical Assistance, Access and Utilization, Program Evaluation and Compliance & Quality Improvement.

Break-Out Themes

- Maintain focus on prevention and early intervention
- Transportation issues prevent access to services locally.
- Voice for consumers, family members, caregivers, parent partners, transition age youth, and older adults
- Local control with safeguards
- Increased employment opportunities for consumers and increased client operated services and programs
- Cultural competence- reduced disparities/increased access to services
- Funding to counties faster! Increase in the number and quality of services for communities (unserved, underserved, inner cities, etc.)

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- Local control of functions, the transition needs to be strategic

What do you believe are the challenges associated with the changes to mental health at the state level? How can these challenges be addressed?

- As a parent, I want to ensure that parents continue to be a part of the state level policy decisions- the voices of parents need to be included.
- There should be an independent review of the health services- a lot of the same people are in charge- people are suffering because people want to do things the “old way”.
- There is a lack of services for the deaf and hard of hearing statewide
- When the decisions are finalized there needs to be a strong foundation to implement those decisions.
- UACF needs to be included in this process; they have more expertise regarding children’s issues and parents/families.
- MHSA is a wonderful opportunity to change the “old way”, but there is not as much inclusion of family members as there should be. Family members need to be included in the process. There need to be more opportunities for supportive services for families so that they can get help before there is a crisis. We need to ask family member what they need for support; we need to be more flexible.
- Stigma and discrimination is a huge problem and needs to be addressed.
- Some of the questions posed today seem more like window dressing. It’s an impossible situation. What can DMH do with only 19 staff? I can’t speak to the placement of functions. Use the guiding principles (below) and do your best to make the decisions.
 1. Retain the integrity of MHSA. The MHSA is the best thing that has happened to mental health.
 2. Mental health needs to be elevated in whatever system is decided upon.
 3. Avoid fragmentation and further complication (silo-ing) of the system
 4. Continue to support consumers and family members
 5. Continue to support multicultural services [the Office of Multicultural Services at DMH] and the California Reducing Disparities Project. Reducing disparities is a national issue and needs a state focus.
- Maintain the voluntary nature of services- no forced commitments (5150’s). There needs to be state level oversight to ensure that MHSA funded programs are voluntary.
- The consumer movement is critical. We deserve human rights and civil rights. That’s what we are fighting for in the consumer movement.
- I agree with the danger of fragmentation. We need unifying principles. If DMH and ADP are folded into DHCS, they should change their name to be more inclusive and unifying.
- Unification of services
- Maintain the focus on the recovery model
- CA has the largest Asian/Pacific Islander population; we cannot lose sight of services for this population.
- Clients and family members need to have input into county plans. We [counties] don’t know what they are talking about until they talk to clients.

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- There needs to be a non-biased, non-political group of consumers and family members to provide state level policy input and oversight.
- Oversight will disappear. The oversight needs to continue on a continual basis – don't wait for something bad to happen first.
- No single person or entity should have complete control.
- There should be a blend of local and state authority.
- There needs to be equity in how counties get money. Currently, there is not equity and many counties, especially smaller, rural counties, are not getting enough funding.
- There is a disparity among veterans and children (in the services they receive) which needs to be addressed.